State of Maine
Developmental Services
Application for Section 21 and Section 29 Waiver Services

Training for Mental Health and Children's Case Managers

Table of Contents

What are Waiver Services?

- When a Member agrees to receive waiver services, they are waiving their rights to an institutional care facility for individuals with intellectual disabilities (ICF/IID)
- Programs provided through Medicaid to assist Members with receiving services in their homes and communities. Services must be medically necessary.

What are Medically Necessary Services?

Medical Necessity or Medically Necessary services are those reasonably necessary medical and remedial services that are:

1. Provided in an appropriate setting;
2. Recognized as standard medical care, based on national standards for best practices and safe, effective, quality care;
3. Required for the diagnosis, prevention and/or treatment of illness, disability, infirmity or impairment and which are necessary to improve, restore or maintain health and well-being;
4. MaineCare covered services (subject to age, eligibility, and coverage restrictions as specified in other Sections of the manual as well as Early and Periodic Screening, Diagnosis and Treatment Services requirements as detailed in Chapter II, Section 94 of the Maine care Benefits Manual.)
5. Performed by enrolled providers within their scope of licensure and/or certification;
6. Provided within the regulations of the Mainecare Benefits Manual.

(References to Chapter 1.02 E of the Maine Care Benefits Manual)

https://www1.maine.gov/sos/cec/rules/10/ch101.htm

Section 21 and Section 29 Waiver Services

Section 21

Is a Comprehensive Waiver Program for Members with Intellectual Disabilities (ID) or Autism Spectrum Disorder (ASD)

Section 29

Is a Support Waiver Program for Members with Intellectual Disabilities (ID) or Autism Spectrum Disorder (ASD)

Section 29 Services

References to Ch. II, §29 of MaineCare Benefits Manual

Section 21 Services

References to Ch. II, §21 of MaineCare Benefits Manual

Home Support Options

Home Support-Quarter Hour (Section 21.07-17 and 29.05-6)

- Direct Support Professionals (DSP) come to the Member's home to assist with tasks and skills related to personal care, health, well-being, and growth.
- Number of hours needed depends on the Member's need for services .
- Ex: The Member may need support with laundry and meal-planning or want someone to teach them how to manage their money. They may need to learn skills to manage their medications or to maintain their home or apartment.

For detailed information, please refer to:

https://www1.maine.gov/sos/cec/rules/10/ch101.htm (Section 21/29)

Home Support Options

Shared-Living (Section 21.05-20 and 29.02-25)

- Is Adult Foster Care
- It is a per diem service but can be used less than 365 days a year under Section 29.
- Members live in a private home and receive support from another person(s) who lives in that home with them. This person, or provider, must meet all the requirements of a *Direct Support Professional (DSP).*
- Some supports include adaptive skill development, assistance with ADLs, community inclusion and transportation.

For detailed information, please refer to:

https://www1.maine.gov/sos/cec/rules/10/ch101.htm (Section 21/Section 29)

Home Support Options

Agency Group Home (Section 21.05-11)

- If the Member needs ***Agency Home Support***, they would live in a ***Group Home*** that varies between 2-6 members who also receive support services.
- On-site daily support that includes personal care, protective oversight, and supervision in accordance with the Member's Personal Plan.
- Staff are available 24 hours a day, 7 days a week to provide the support that the Member needs.

For detailed information, please refer to:

https://www1.maine.gov/sos/cec/rules/10/ch101.htm (Section 21)

Community Support Options

Community Support (Section 21.05-20 and 29.02-25)

- A habilitative service with a focus on community inclusion, personal development, and support in areas of daily living skills if necessary. Goals are to increase or maintain a Member's ability to successfully engage in inclusive social and community relationships and to maintain and develop skills that support health and well-being.
- Provided by a Direct Support Professional employed by an OADS approved provider.
- Flexible, responsive, and provided to Members as defined by the Member's choice and needs as documented in the Member's Personal Plan.
- The location of the service and staffing level may vary, allowing for a mix of individualized and group services.
- Allow for opportunities for career exploration and the facilitation of discussions about the benefits of working.

Work Supports

Work Supports (Section 21.05-23 and Section 29.05-20)

- Maine is an Employment First state. This means that work supports are the first and preferred service option. OADS believes all people can work and provides supports to maintain employment.
- Assistance includes planning for employment, discovering interests and abilities, and accessing services that will assist someone on their path to employment.
- Obtaining employment and building skills in an integrated business alongside of co-workers without disabilities making equitable wages and benefits is the desired outcome.
- Includes Career Planning, Work Supports and Employment Specialist Services

Application Forms

Section 29

Section 29- Supports Waiver Application Process

The Case Manager is responsible for submitting an Application for Waiver services. An Application consists of the following :

1. A completed **Developmental Services Home and Community Based Waiver Assessment (BMS-99) (Word)**

   BMS99 is used to determine medical eligibility for waiver services

2. A completed **Section 29 Cover Sheet (Word)**
3. A completed **Personal Plan Update Form (Word),** signed by the Individual/Guardian and the current Individual Service Plan (ISP). ***Describes what staff will do to/with/for the Member.***
4. A completed **Yearly Cost Estimate for Services (Excel)**

Completed Applications must be **Emailed** to **HCBS.waiver@maine.gov**

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Aging and Disability Services
11 State House Station
41 Anthony Avenue
Augusta, Maine 04333-0011
Tel: (207) 287-9200; Toll Free: (800) 262-2232
Fax (Disability) (207) 287-9915; Fax (Aging) (207)287-9229
TTY: Dial 711 (Maine Relay

Developmental Services Home and Community Based (HCB) Waiver Assessment (BMS-99)

To determine initial medical eligibility for Comprehensive (Section 21) or Support (Section 29) Waiver services, the below functional assessment must be completed by the Case Manager. Every twelve (12) months from the date of initial eligibility approval, an updated assessment form must be completed and submitted to the Department.

It MUST be saved in WORD, in order for the Waiver Mgr. Assistant to cut and paste this information into EIS.

☐ Initial Classification / ☐ Reclassification

Member Legal Name: Click here to enter text.	**Date of Birth:** Click here to enter text.
EIS #: Click here to enter text.	**MaineCare #:** Click here to enter text.
Current Diagnosis: Diagnosis applicable to Developmental Services should be listed first, then other Mental Health and medical diagnosis second.	
Legal Representative(s) (If applicable): Click here to enter text. **Legal Representative Address:** Click here to enter text.	**Legal Representative Email Address:** Click here to enter text. **Legal Representative Phone #:** Click here to enter text.
Date last consumer planning meeting recommends ICF/IID or Waiver level of Services:	Click or tap to enter a date.

The Home and Community Based Benefit (HCB or Benefit) is offered in a community-based setting as an alternative for members who qualify to live in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID- Section 50). HCB gives members eligible for this Benefit the option to live in their own home or in another home in the community thus avoiding or delaying institutional services.

Examples of Covered ICF-IID (Section 50) Services

The following are examples of ICF-IID group home facility services and conditions. Any combination of examples may equate the needs for ICF-IID group home facility services.

1. Independent in mobility or in the use of a wheelchair or other mobility device.
2. May need assistance in personal care such as oral hygiene, care of skin, personal grooming and bathing.
3. May exhibit or has exhibited deviation from acceptable behavior.
4. May require some personal supervision.
5. May require some protection from environmental hazards.
6. [illegible] participate, under supervision, in diversional and motivational activities both in the facility and in the community.
7. [illegible] participate in one or more developmental, vocational or community programs.
8. Medications ordered by the physician are of a routine nature that can be administered by qualified group home facility personnel.
9. May be aphasic.

Summary of observed behavior and social history which determined level of need of care, based on ICF/IID examples:

4000 Character Limit

Choose the Letter that Best applies and Explain

A= Independent, B= Needs Supervision, C= Needs Skills Training, D= Needs Physical Assistance, E= Total Care

Indicate level of support for ALL subdomains. If subdomain is NOT independent describe in the text box.

A.) Activates of Daily Living

Eating	Choose
Dressing	Choose
Toileting	Choose
Bathing	Choose
Grooming	Choose
Mobility	Choose

4000 Character Limit

B.) Safety

Avoidance of physical danger	Choose
Avoidance of emotional jeopardy	Choose
Engagement in healthy relationships	Choose
Judgement regarding personal conduct	Choose

4000 Character Limit

C.) Household Activities

Cooking	Choose
Laundry	Choose

4000 Character Limit

D.) Community Access

Shopping	Choose
Transportation	Choose
Banking	Choose
Recreation	Choose

4000 Character limit

E.) Maintains Relationships

Family	Choose
Friends	Choose
Coworkers	Choose
Support Staff	Choose

4000 Character limit

F.) Health Maintenance

Accessing Medical Care	Choose
Emergency First-Aid	Choose
Accessing Mental Health Care	Choose
Medication Administration	Choose

4000 Character limit

G.) Communication

Expressive Communications	Choose
Receptive Communications	Choose
Sign Language	Choose
Visual/Gestural	Choose

4000 Character limit

Name of Person Completing Assessment and Title: Click here to enter text.	**Date of Review:** Click or tap to enter a date.

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Aging and Disability Services
11 State House Station
41 Anthony Avenue
Augusta, Maine 04333-0011
Tel: (207) 287-9200; Toll Free: (800) 262-2232
Fax (Disability): (207) 287-9055; Fax (Aging): (207)287-9229
TTY: Dial 711 (Maine Relay

Section 29 Supports Waiver Application Form

Member Legal Name: Click here to enter text.	**Date of Birth:** Click here to enter text.
EIS # (If known): Click here to enter text.	**MaineCare #:** Click here to enter text.
Mailing Address: Click here to enter text.	
Legal Guardian (s): Click here to enter text. **Guardian Address:** Click here to enter text.	**Guardian Email Address:** Click here to enter text. **Guardian Phone #:** Click here to enter text.
Case Manager: Click here to enter text. **CM Agency:** Click here to enter text.	**Case Mgr. Email address:** Click here to enter text. **Case Mgr. Phone #:** Click here to enter text.
Person Completing Form Click or tap here to enter text.	**Date Form Completed:** Click or tap to enter a date.

Please provide all requested materials:

1. A signed current **Person-Centered Plan Face Sheet** (both pages) or Personal Plan (**MH or Children's Case Management**)
2. A completed **DS Support HCB Waiver Assessment** (commonly referred to as a BMS-99) saved in **EIS** and not locked or a completed Developmental Services Home and Community Based (HCB Waiver) Assessment (BMS-99) located at: http://www.maine.gov/dhhs/oads/provider/developmental-services/forms-protocols.html (**MH or Children's Case Managers**)
3. A completed Yearly Cost Estimate located at: http://www.maine.gov/dhhs/oads/provider/developmental-services/forms-protocols.html

Complete Application Packets can be sent by email to the Developmental Services Waiver Assistant or mail
US Postal Service to:

Developmental Services Waiver Assistant
c/o DHHS-OADS
41 Anthony Ave.
Augusta, ME 04333-0011

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Aging and Disability Services
11 State House Station
41 Anthony Avenue
Augusta, Maine 04333-0011
Tel: (207) 287-9200; Toll Free: (800) 262-2232
Fax (Disability) (207) 287-9915; Fax (Aging) (207)287-9229
TTY: Dial 711 (Maine Relay

Personal Plan* for Developmental Services

*This Personal Plan serves as an attachment to an Individual Support Plan (ISP) or Individual Plan of Care (IPC) for Members seeking to access Section 21/29 Waiver Services. To minimize duplication, if a section below corresponds to a completed section on the ISP/ IPC, indicate "see corresponding section" and note the specific location on the ISP/IPC.

Member Name:Click or tap here to enter text.	Date of Birth: Click or tap to enter a date.
MaineCare #:Click or tap here to enter text.	EIS # (if Known):Click or tap here to enter text.
Guardian (if applicable):Click or tap here to enter text.	Co-Guardian (if applicable): Click or tap here to enter text.
Date of Meeting: Click or tap to enter a date.	Plan Start Date: Click or tap to enter a date.

List names and affiliations/relationships of all team members who participated in planning:

1. Click or tap here to enter text.
2. Click or tap here to enter text.
3. Click or tap here to enter text.
4. Click or tap here to enter text.
5. Click or tap here to enter text.
6. Click or tap here to enter text.

Additional Space to add team Members (if Applicable): Click or tap here to enter text.

Member's Strengths and Preferences

Describe person's strengths, abilities and interests.

Needs of the Member

Reflect Clinical and Support Needs as Identified Through and Assessment of Functional Need. Include any Risk Factors:

Click or tap here to enter text.

Goals and Desired Outcomes

List all the Member's Goals and Desired Outcomes (in plain language), including the Member's goals for strengthening and cultivating personal, community, family, and professional relationships. This is not intended to be a Habilitation Plan. List goals that the member wants to achieve/have or do in the coming year(s). Try to list them from the member's perspective.

EXAMPLES OF GOALS AND DESIRED OUTCOMES
Home Supports: I would like to be able to wash my clothes by myself.
Community Supports: I would like to be able to go to a concert in the park.
Work Supports: I want to be able to have money to spend on trips.

1. Click or tap here to enter text.
2. Click or tap here to enter text.
3. Click or tap here to enter text.
4. Click or tap here to enter text.
5. Click or tap here to enter text.
6. Click or tap here to enter text.

Additional Space for Goals and Desired Outcomes (if Applicable): Click or tap here to enter text.

Home and Community Based Services and Supports

List Current and **Proposed** Services to assist the Member in achieving the above identified goals. This includes all Maine Care Benefit services determined medically necessary by the team, and includes all other services (i.e. NET Transportation) and/or natural supports that may not be covered under Section 21 or Section 29 but the Member identifies and may access:

Name of Provider	Type of Service	Duration and Frequency (days per week/hours per day)
Click or tap here to enter text.	Choose an item.	Click or tap here to enter text.
Click or tap here to enter text.	Choose an item.	Click or tap here to enter text.
Click or tap here to enter text.	Choose an item.	Click or tap here to enter text.
Click or tap here to enter text.	Choose an item.	Click or tap here to enter text.
Click or tap here to enter text.	Choose an item.	Click or tap here to enter text.

Additional Space to Add Other Services and/or Natural Supports (if Applicable). Click or tap here to enter text.

Describe what services and supports identified above will do **To/With/For** the Member. For any Risk Factors identified, include measures to minimize them (i.e. Backup Plans):

EXAMPLES:

- **Agency staff will provide reminders for member to complete daily hygiene routines.**
- **Staff will provide prompts /cues and physical assistance as needed with meal preparation.**
- **Community Support Staff will model appropriate social interactions with peers, community members, and other staff.**
- **Staff will prompt member to identify events in their community that they want to attend.**
- **Work support staff will be needed to prompt and cue member to remain on task at work and to follow employer rules and expectations.**

RESPITE is NOT a service under Section 21.

Click or tap here to enter text.

Personal Plan Meeting Narrative

Include in the Narrative:

1. Date and location of meeting at convenience to the Member.
2. Attendees (First, last & relationship or affiliation) the Member chose to be at his/her meeting.
3. Cultural considerations and/or accommodations needed to ensure planning is accessible to the Member.
4. Informed choice regarding the services and supports the Member receives and from whom.
5. Conflict of interest guidelines, including ensuring providers of waiver services do not provide Case Management services or develop the Personal Plan.
6. How services contribute to the Member's health and well-being and the member's ability to reside in a community setting. **Ensure you are discussing any health and safety issues that are present or anticipated in the coming year and how Waiver services can address them.**
7. Alternative home and community-based settings considered by the Member.
8. Unmet needs and interim plans to meet those needs (if applicable).
9. The individual and/or entity responsible for monitoring the plan.
10. Written notification to the Member and/or Guardian regarding the grievance process which can be located at http://www.maine.gov/dhhs/oads/home-support/disability-with-autism/grievance-process.html.

Click or tap here to enter text.

I approve the plan dated Click or tap to enter a date.. **I understand that I may request to update my plan or revoke my approval at any or all parts of this plan at any time.**

Individual	Date
Guardian	Date
Guardian	Date

By signing, I agree this plan accurately reflects the planning process and the person's needs and desires. The recommended MaineCare services are medically necessary and in compliance with MaineCare rules.

Case Manager	Date

Yearly Cost Estimate for Services (Excel)

INSTRUCTIONS						
Information should only be entered in the orange cells.						
Do not enter anything into the light gray cells, these cells are formulated.						
SECTION 29 SERVICE	**Number of Members**	**Hours Per Week**	**Units Per Year**	**RATE**	**Cost Per Year**	**Combined Cap $58,168.50**
Assistive Technology						
Assistive Technology - Assessment (**max 32 units per fiscal year**) *Enter number of units in "Units*		N/A	0.00	$8.37	$0.00	
Assistive Technology - Transmission (Utility Service) *Enter in months of service in "Units Per Year" field*		N/A	0.00	$50.00	$0.00	
Assistive Technology - Devices (Monitoring feature/device, stand alone or integrated, any type , includes all accessories, components and electronics, not otherwise classified. (**max $6000**) *Enter in "Cost Per Year" field*		N/A	N/A	N/A	$0.00	
Community Supports:						
Community Support (**not to exceed $58,168.50/ yr**)		0.00	0.00	$6.53	$0.00	$0.00
Community Support with Medical Add On (**not to exceed $58,168.50/ yr**)		0.00	0.00	$8.05	$0.00	$0.00
Home Based Services						
Home Supports:						
Home Support (quarter hour) **Not to exceed combined cap of $58,168.50/ yr**		0.00	0.00	$7.75	$0.00	$0.00
Home Support (Remote - Monitor Only) **Not to exceed combined cap of $58,168.50/yr.**		0.00	0.00	$1.63	$0.00	$0.00
Home Support (Remote - Interactive) **Not to exceed combined cap of $58,168.50/yr.**		0.00	0.00	$7.75	$0.00	$0.00
Shared Living:						
Shared Living *Select "Number of Members Served" in home (if known, otherwise keep 1) and Enter number of days in "Units Per Year" field* **Not to exceed combined cap of $58,168.50**	1	N/A	0.00	$156.00	$0.00	$0.00
Home Accessibility						
Home Accessibility Adaptations (repairs) *Enter in "Cost Per Year" field*		N/A	N/A	N/A	$0.00	
Home Accessibility Adaptations (home modifications) **Not to exceed $10,000 in a 5 year period**		N/A	N/A	N/A	$0.00	

1. Community Support: Here is an example of 19 hours/weekly of Community Support (orange cell) and it's annual cost of $25,806.56 (blue cell)

Community Supports:						
Community Support **(not to exceed $58,168.50/ yr)**		19.00	3,952.00	$6.53	$25,806.56	$25,806.56

2. **Work Support**: In this example the Member is receiving 7 hours/weekly of Work Supports (orange cell) and it's annual cost of 12,317

Work Supports					
Work Support (Individual/Group) *Select "Number of Members Served" at work site (if known, otherwise*	1	7.00	1,456.00	$8.46	$12,317.76

3. Shared Living : Here is an example of Shared Living at 365 days per year (orange cell) and it's annual cost of $56,940.00 (blue cell)

Shared Living:						
Shared Living *Select "Number of Members Served" in home (if known, otherwise keep 1) and Enter number of days in "Units Per Year" field* **Not to exceed combined cap of $58,168.50**	1	N/A	365.00	$156.00	$56,940.00	$56,940.00

4. Home Supports: Here is an example of a Member needing 23 hrs./week of HS Quarter Hour (orange cell) and it's annual cost of $37,076.00 (blue cell)

Home Supports:						
Home Support (quarter hour) **Not to exceed combined cap of $58,168.50/ yr**		23.00	4,784.00	$7.75	$37,076.00	$37,076.00

Next Steps
Section 29 Support Waiver

- Completed Applications must be **Emailed** to **HCBS.waiver@maine.gov**
- Applications are dated as they are received.

  (BMS-99 in EIS also documents date received)
- Section 29 applications will be reviewed in the order they are received and are placed on a waiting list based on receipt date.
- There are no priority levels in Section 29.
- If you do not receive an email confirmation within 2 business days after emailing an application, please send an email to

  HCBS.waiver@maine.gov
- ** If you are unable to email your application, please email **HCBS.waiver@maine.gov** for further direction.

Application

Section 21

Section 21- Comprehensive Waiver Application Process

The Case Manager is responsible for submitting an Application for Waiver services. An Application consists of the following :

1. A completed **Developmental Services Home and Community Based Waiver Assessment (BMS-99) (Word)**

   BMS99 is used to determine medical eligibility for waiver services

2. A completed **Section 21 Waiver Information Form (Word)**

   Assists waiver manager in determining the Member's level of need

3. A completed **Personal Plan Update Form (Word),** signed by the Individual/Guardian and the current Individual Service Plan (ISP). ***Describes what staff will do to/with/for the Member.***

4. A completed **Yearly Cost Estimate for Services (Excel)**

Completed Applications must be **Emailed** to **HCBS.waiver@maine.gov**

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Aging and Disability Services
11 State House Station
41 Anthony Avenue
Augusta, Maine 04333-0011
Tel: (207) 287-9200; Toll Free: (800) 262-2232
Fax (Disability) (207) 287-9915; Fax (Aging) (207)287-9229
TTY: Dial 711 (Maine Relay

Developmental Services Home and Community Based (HCB) Waiver Assessment (BMS-99)

To determine initial medical eligibility for Comprehensive (Section 21) or Support (Section 29) Waiver services, the below functional assessment must be completed by the Case Manager. Every twelve (12) months from the date of initial eligibility approval, an updated assessment form must be completed and submitted to the Department.

It MUST be saved in WORD, in order for the Waiver Mgr. Assistant to cut and paste this information into EIS.

☐ **Initial Classification** / ☐ **Reclassification**

Member Legal Name: Click here to enter text.	**Date of Birth:** Click here to enter text.
EIS #: Click here to enter text.	**MaineCare #:** Click here to enter text.
Current Diagnosis: Diagnosis applicable to Developmental Services should be listed first, then other Mental Health and medical diagnosis second.	
Legal Representative(s) (If applicable): Click here to enter text. **Legal Representative Address:** Click here to enter text.	**Legal Representative Email Address:** Click here to enter text. **Legal Representative Phone #:** Click here to enter text.
Date last consumer planning meeting recommends ICF/IID or Waiver level of Services:	Click or tap to enter a date.

The Home and Community Based Benefit (HCB or Benefit) is offered in a community-based setting as an alternative for members who qualify to live in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID- Section 50). HCB gives members eligible for this Benefit the option to live in their own home or in another home in the community thus avoiding or delaying institutional services.

Examples of Covered ICF-IID (Section 50) Services

The following are examples of ICF-IID group home facility services and conditions. Any combination of examples may equate the needs for ICF-IID group home facility services.

1. Independent in mobility or in the use of a wheelchair or other mobility device.
2. May need assistance in personal care such as oral hygiene, care of skin, personal grooming and bathing.
3. May exhibit or has exhibited deviation from acceptable behavior.
4. May require some personal supervision.
5. May require some protection from environmental hazards.
6. Is able to participate, under supervision, in diversional and motivational activities both in the facility and in the community.
7. Is able to participate in one or more developmental, vocational or community programs.
8. Medications ordered by the physician are of a routine nature that can be administered by qualified group home facility personnel.
9. May be aphasic.

Summary of observed behavior and social history which determined level of need of care, based on ICF/IID examples:

4000 Character Limit

Choose the Letter that Best applies and Explain

A= Independent, B= Needs Supervision, C= Needs Skills Training, D= Needs Physical Assistance, E= Total Care

Indicate level of support for ALL subdomains. If subdomain is NOT independent describe in the text box.

A.) Activates of Daily Living

Eating	Choose
Dressing	Choose
Toileting	Choose
Bathing	Choose
Grooming	Choose
Mobility	Choose

4000 Character Limit

B.) Safety

Avoidance of physical danger	Choose
Avoidance of emotional jeopardy	Choose
Engagement in healthy relationships	Choose
Judgement regarding personal conduct	Choose

4000 Character Limit

C.) Household Activities

Cooking	Choose
Laundry	Choose

4000 Character Limit

D.) Community Access

Shopping	Choose
Transportation	Choose
Banking	Choose
Recreation	Choose

4000 Character limit

E.) Maintains Relationships

Family	Choose
Friends	Choose
Coworkers	Choose
Support Staff	Choose

4000 Character limit

F.) Health Maintenance

Accessing Medical Care	Choose
Emergency First-Aid	Choose
Accessing Mental Health Care	Choose
Medication Administration	Choose

4000 Character limit

G.) Communication

Expressive Communications	Choose
Receptive Communications	Choose
Sign Language	Choose
Visual/Gestural	Choose

4000 Character limit

Name of Person Completing Assessment and Title: Click here to enter text.	**Date of Review:** Click or tap to enter a date.

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Aging and Disability Services
11 State House Station
41 Anthony Avenue
Augusta, Maine 04333-0011
Tel: (207) 287-9200; Toll Free: (800) 262-2232
Fax (Disability) (207) 287-9915; Fax (Aging) (207)287-9229
TTY: Dial 711 (Maine Relay

Section 21 Waiver Information Form

This form assists the Waiver Manager in determining the member's current level of need.

Ensure all fields are filled out completely, and provide as much detail as you can.

I. MEMBER INFORMATION:

Member Legal Name: Click here to enter text.	**Date of Birth:** Click here to enter text.
EIS # (If known): Click here to enter text.	**MaineCare #:** Click here to enter text.
Mailing Address: Click here to enter text.	
Legal Guardian (s): Click here to enter text. **Guardian Address:** Click here to enter text.	**Guardian Email Address:** Click here to enter text. **Guardian Phone #:** Click here to enter text.
Case Manager: Click here to enter text. **CM Agency:** Click here to enter text.	**Case Mgr. Email address:** Click here to enter text. **Case Mgr. Phone #:** Click here to enter text.
Person Completing Form: Click or tap here to enter text.	**Date Form Completed:** Click or tap to enter a date.

Complete 1st Section Only if Wanting to Remain on the Waiting List. No Additional Documentation Required

1. Do you want to remain on the waiting list Waiting List? (**Notification or Reconsideration**) ☐ Yes ☐ No
2. Is the member receiving any services? ☐ Yes ☐ No
   If yes, please choose: Choose an item.
   If other, please explain: **List any other services that the member is currently receiving here: i.e. Section 28, School, Mental Health Services.**
3. Types of Services that are needed (check all that apply and explain):

☐ Home Supports – please choose Choose an item. ☐ Community ☐ Work ☐ Respite
☐ Assisted Technology ☐ Crisis services ☐ Behavioral Consultation ☐ Communication Devices/Assessments
☐ Other Consultation Services/Assessments ☐ Other
Please explain: Click here to enter text.

This form must be completed and returned to the Office of Aging & Disability Services (OADS) for Annual Waiting List Confirmation Review as outlined in MaineCare Benefits Manual Chapter II §21.03-6d.
If we do not receive this form you may be removed from the waiting list.

For an initial application or reconsideration of priority, please complete entire form.

☐ Initial Application / ☐ Reconsideration of Priority

II. Living Situation

1. Where is the member currently living? Choose an item.
   If other, please explain: Click here to enter text.
2. Have the member's living arrangements changed? ☐ Yes ☐ No
   If yes, please explain: Click here to enter text.
3. Is the member living in unsafe circumstances? ☐ Yes ☐ No
   If yes, please explain: Click here to enter text.

Complete below if relevant for services now, and if the age of the caregiver is relevant for determining priority level.

III. CAREGIVER INFORMATION:

Primary Caregiver's name (s): Click here to enter text.	**Age:** Click here to enter text.
Relationship to Member: Click here to enter text.	

1. Is the caregiver having difficulty caring for the member? ☐ Yes ☐ No
   If yes, please explain: Click here to enter text.
2. Does primary caregiver have a terminal illness? ☐ Yes ☐ No

If yes, is another responsible or willing caregiver available? ☐ Yes ☐ No

Who/Relationship to Member? Click here to enter text.

IV. **Health and Safety:**

In the past 12 months, has a report been filed with DHHS on behalf of the member, due to abuse, neglect and/or exploitation? ☐ Yes ☐ No **You should include any reports made to DHHS/Adult Protective Services here.**

If yes, please specify date of most recent report and a brief explanation. Click or tap here to enter text.

1. Is the health, safety or welfare of the member in danger? ☐ Yes ☐ No
   If yes, please explain. Click here to enter text.
2. Is the health, safety or welfare of others in danger, due to the member's needs? ☐ Yes ☐ No
   If yes, please explain. Click here to enter text.
3. Within the last 12 months, has the member (check all that apply and explain):

   ☐ Increased functional needs and required supports, as a result of a mental health or medical condition. Please list all current diagnosis. Click or tap here to enter text.

   ☐ Criminal behavior resulting in involvement with the Criminal Justice System (not dependent upon conviction) that impacts or results in the harm or threat to others.

   ☐ Three or more hospital admissions over the last 12 months due to a medical or behavioral decline that is expected to continue. **If there have been any hospital admissions, please provide a short description and dates/length of stay.**

   ☐ Prolonged and unresolved Crisis Involvement resulting in high-risk for institutionalization **Briefly describe any Crisis Involvement**
   Please explain: Click here to enter text.
4. Is the member at risk for abuse, neglect, and/or exploitation in the absence of, the provision of benefit services, identified in the service plan? ☐ Yes ☐ No **What could happen without the requested waiver services.**
   If yes, please explain: Click here to enter text.

Please include the following Items for Initial Applications and/or Reconsideration of Priority:

1. A signed current Person-Centered Plan Face Sheet (both pages) or Personal Plan (**MH or Children's Case Management**)
2. A completed **DS Comprehensive HCB Waiver Assessment** (commonly referred to as a BMS-99) saved in **EIS** and **not locked** or a completed BMS-99 assessment at: http://www.maine.gov/dhhs/oads/provider/developmental-services/forms-protocols.html
   (MH or Children's Case Management)
3. A completed Yearly Cost Estimate at: http://www.maine.gov/dhhs/oads/provider/developmental-services/forms-protocols.html
4. Provide all relevant/current documents that will support eligibility and priority determination

Please Send Completed Application by Email to the Developmental Services Waiver Assistant or by Mail To:

Developmental Services Waiver Assistant
c/o DHHS/OADS
41 Anthony Ave State House Station 11
Augusta Maine 04333-0011

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Aging and Disability Services
11 State House Station
41 Anthony Avenue
Augusta, Maine 04333-0011
Tel: (207) 287-9200; Toll Free: (800) 262-2232
Fax (Disability) (207) 287-9915; Fax (Aging) (207)287-9229
TTY: Dial 711 (Maine Relay

Personal Plan* for Developmental Services

*This Personal Plan serves as an attachment to an Individual Support Plan (ISP) or Individual Plan of Care (IPC) for Members seeking to access Section 21/29 Waiver Services. To minimize duplication, if a section below corresponds to a completed section on the ISP/ IPC, indicate "see corresponding section" and note the specific location on the ISP/IPC.

Member Name:Click or tap here to enter text.	Date of Birth: Click or tap to enter a date.
MaineCare #:Click or tap here to enter text.	EIS # (if Known):Click or tap here to enter text.
Guardian (if applicable):Click or tap here to enter text.	Co-Guardian (if applicable): Click or tap here to enter text.
Date of Meeting: Click or tap to enter a date.	Plan Start Date: Click or tap to enter a date.

List names and affiliations/relationships of all team members who participated in planning:

1. Click or tap here to enter text.
2. Click or tap here to enter text.
3. Click or tap here to enter text.
4. Click or tap here to enter text.
5. Click or tap here to enter text.
6. Click or tap here to enter text.

Additional Space to add team Members (if Applicable): Click or tap here to enter text.

Member's Strengths and Preferences

Describe person's strengths, abilities and interests.

Needs of the Member

Reflect Clinical and Support Needs as Identified Through and Assessment of Functional Need. Include any Risk Factors:

Click or tap here to enter text.

Goals and Desired Outcomes

List all the Member's Goals and Desired Outcomes (in plain language), including the Member's goals for strengthening and cultivating personal, community, family, and professional relationships. This is not intended to be a Habilitation Plan. List goals that the member wants to achieve/have or do in the coming year(s). Try to list them from the member's perspective.

EXAMPLES OF GOALS AND DESIRED OUTCOMES
Home Supports: I would like to be able to wash my clothes by myself.
Community Supports: I would like to be able to go to a concert in the park.
Work Supports: I want to be able to have money to spend on trips.

1. Click or tap here to enter text.
2. Click or tap here to enter text.
3. Click or tap here to enter text.
4. Click or tap here to enter text.
5. Click or tap here to enter text.
6. Click or tap here to enter text.

Additional Space for Goals and Desired Outcomes (if Applicable): Click or tap here to enter text.

Home and Community Based Services and Supports

List Current and Proposed Services to assist the Member in achieving the above identified goals. This includes all Maine Care Benefit services determined medically necessary by the team, and includes all other services (i.e. NET Transportation) and/or natural supports that may not be covered under Section 21 or Section 29 but the Member identifies and may access:

Name of Provider	Type of Service	Duration and Frequency (days per week/hours per day)
Click or tap here to enter text.	Choose an item.	Click or tap here to enter text.
Click or tap here to enter text.	Choose an item.	Click or tap here to enter text.
Click or tap here to enter text.	Choose an item.	Click or tap here to enter text.
Click or tap here to enter text.	Choose an item.	Click or tap here to enter text.
Click or tap here to enter text.	Choose an item.	Click or tap here to enter text.

Additional Space to Add Other Services and/or Natural Supports (if Applicable). Click or tap here to enter text.

Describe what services and supports identified above will do **To/With/For** the Member. For any Risk Factors identified, include measures to minimize them (i.e. Backup Plans):

EXAMPLES:

- **Agency staff will provide reminders for member to complete daily hygiene routines.**
- **Staff will provide prompts /cues and physical assistance as needed with meal preparation.**
- **Community Support Staff will model appropriate social interactions with peers, community members, and other staff.**
- **Staff will prompt member to identify events in their community that they want to attend.**
- **Work support staff will be needed to prompt and cue member to remain on task at work and to follow employer rules and expectations.**

RESPITE is NOT a service under Section 21.

Click or tap here to enter text.

Personal Plan Meeting Narrative

Include in the Narrative:

1. Date and location of meeting at convenience to the Member.
2. Attendees (First, last & relationship or affiliation) the Member chose to be at his/her meeting.
3. Cultural considerations and/or accommodations needed to ensure planning is accessible to the Member.
4. Informed choice regarding the services and supports the Member receives and from whom.
5. Conflict of interest guidelines, including ensuring providers of waiver services do not provide Case Management services or develop the Personal Plan.
6. How services contribute to the Member's health and well-being and the member's ability to reside in a community setting. **Ensure you are discussing any health and safety issues that are present or anticipated in the coming year and how Waiver services can address them.**
7. Alternative home and community-based settings considered by the Member.
8. Unmet needs and interim plans to meet those needs (if applicable).
9. The individual and/or entity responsible for monitoring the plan.
10. Written notification to the Member and/or Guardian regarding the grievance process which can be located at http://www.maine.gov/dhhs/oads/home-support/disability-with-autism/grievance-process.html.

Click or tap here to enter text.

I approve the plan dated Click or tap to enter a date.. **I understand that I may request to update my plan or revoke my approval at any or all parts of this plan at any time.**

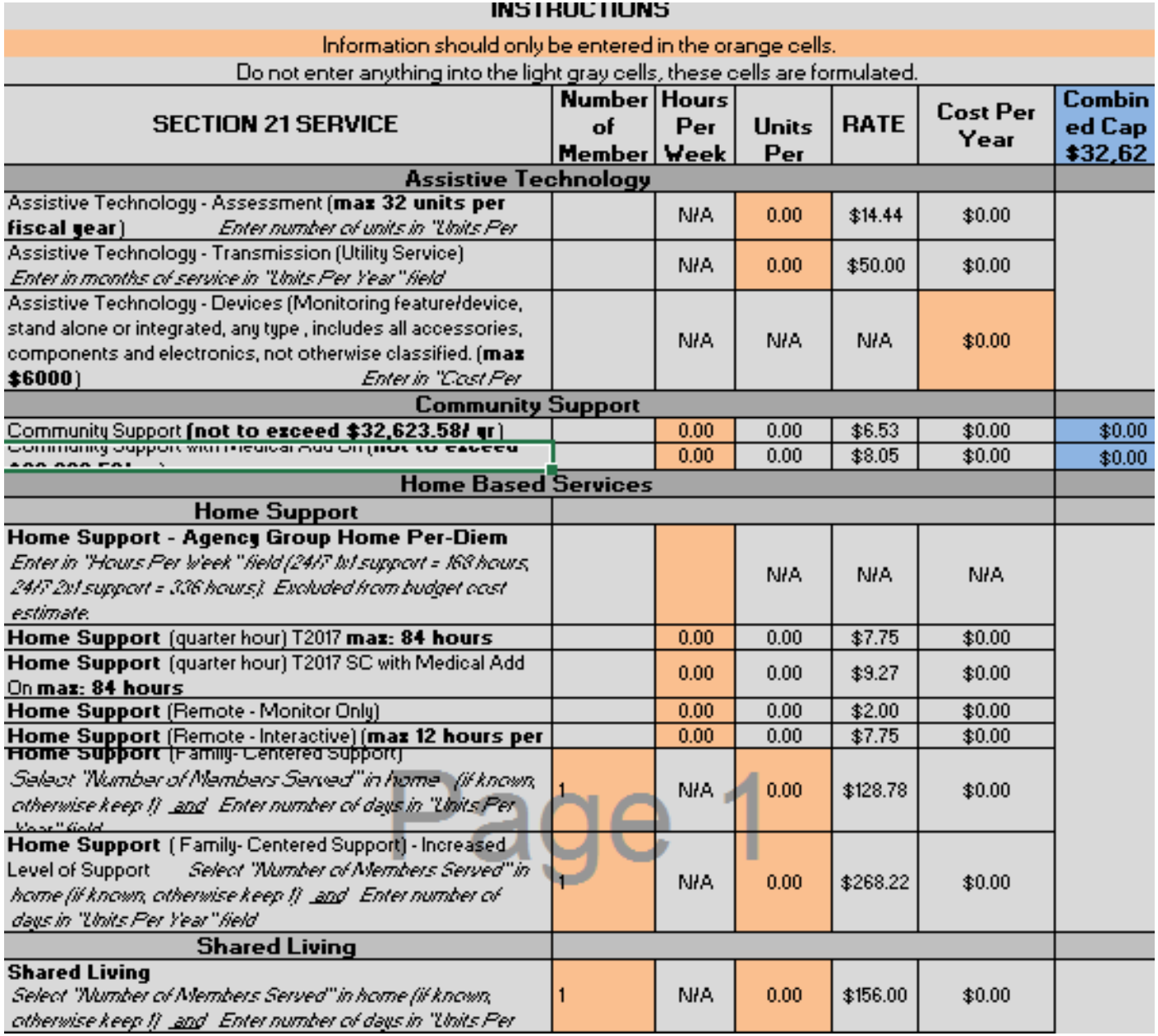
Individual	Date
Guardian	Date
Guardian	Date

By signing, I agree this plan accurately reflects the planning process and the person's needs and desires. The recommended MaineCare services are medically necessary and in compliance with MaineCare rules.

Case Manager	Date

Yearly Cost Estimate for Services (Excel)

The team determines how many units of support are necessary for each service. All information is entered in the orange cells only.



INSTRUCTIONS

Information should only be entered in the orange cells.

Do not enter anything into the light gray cells, these cells are formulated.

SECTION 21 SERVICE	Number of Member	Hours Per Week	Units Per	RATE	Cost Per Year	Combined Cap $32,62
Assistive Technology						
Assistive Technology - Assessment (**max 32 units per fiscal year**) *Enter number of units in "Units Per*		N/A	0.00	$14.44	$0.00	
Assistive Technology - Transmission (Utility Service) *Enter in months of service in "Units Per Year" field*		N/A	0.00	$50.00	$0.00	
Assistive Technology - Devices (Monitoring feature/device, stand alone or integrated, any type , includes all accessories, components and electronics, not otherwise classified. (**max $6000**) *Enter in "Cost Per*		N/A	N/A	N/A	$0.00	
Community Support						
Community Support **(not to exceed $32,623.58/ yr)**		0.00	0.00	$6.53	$0.00	$0.00
[illegible]		0.00	0.00	$8.05	$0.00	$0.00
Home Based Services						
Home Support						
Home Support - Agency Group Home Per-Diem *Enter in "Hours Per Week" field (24/7 1x1 support = 168 hours, 24/7 2x1 support = 336 hours). Excluded from budget cost estimate.*			N/A	N/A	N/A	
Home Support (quarter hour) T2017 **max: 84 hours**		0.00	0.00	$7.75	$0.00	
Home Support (quarter hour) T2017 SC with Medical Add On **max: 84 hours**		0.00	0.00	$9.27	$0.00	
Home Support (Remote - Monitor Only)		0.00	0.00	$2.00	$0.00	
Home Support (Remote - Interactive) (**max 12 hours per**		0.00	0.00	$7.75	$0.00	
Home Support (Family- Centered Support) *Select "Number of Members Served" in home (if known, otherwise keep 1) and Enter number of days in "Units Per Year" field*	1	N/A	0.00	$128.78	$0.00	
Home Support (Family- Centered Support) - Increased Level of Support *Select "Number of Members Served" in home (if known, otherwise keep 1) and Enter number of days in "Units Per Year" field*	1	N/A	0.00	$268.22	$0.00	
Shared Living						
Shared Living *Select "Number of Members Served" in home (if known, otherwise keep 1) and Enter number of days in "Units Per*	1	N/A	0.00	$156.00	$0.00	

1. Community Support: In this example the Member is receiving 22.5 hours/weekly of Community Support (orange cell) and it's annual cost of $30,560.40 (blue cell)

Community Support						
Community Support **(not to exceed $32,623.58/ yr)**		22.50	4,680.00	$6.53	$30,560.40	$30,560.40

2. **Work Support**: In this example the Member is receiving 7 hours/weekly of Work Supports (orange cell) and it's annual cost of 12,317

Work Supports:						
Work Support (Individual/Group) **(not to exceed 32,623.58/ yr)** Select "Number of Members Served" at work site (if known, otherwise keep 1) and Enter number of days in "Units Per Year" field	1	7.00	1,456.00	$8.46	$12,317.76	

3. Home Support: Agency Group Home Per Diem: In this example the Member is receiving 168 hours of 24/7 supports (orange cell)

Home Support						
Home Support - Agency Group Home Per-Diem *Enter in "Hours Per Week" field (24/7 1x1 support = 168 hours, 24/7 2x1 support = 336 hours). Excluded from budget cost estimate.*		168.00	N/A	N/A	N/A	

4. Shared Living : In this example the Member is receiving Shared Living at 365 days per year (orange cell) and it's annual cost of $56,940.00

Shared Living						
Shared Living *Select "Number of Members Served" in home (if known, otherwise keep 1) and Enter number of days in "Units Per Year" field*	1	N/A	365.00	$156.00	$56,940.00	

5. Home Supports: **Quarter Hour:** In this example the Member is needing 84 hours/week of HS Quarter hour (orange cell) and it's annual cost of $135,408 (gray cell)

Home Support (quarter hour) T2017 max: 84 hours		84.00	17,472.00	$7.75	$135,408.00

Next Steps
Section 21 Comprehensive Waiver

- Completed Applications must be **Emailed** to **HCBS.waiver@maine.gov**
- Waiver Manager processes/reviews applications for Section 21 and sets Priority Status.
- Waiver Manager Assistant sends letter to Member/Guardian documenting medical eligibility and priority level assignment.
- If you do not receive an email confirmation within 2 business days after emailing an application, please send an email to **HCBS.waiver@maine.gov**
- ** If you are unable to email your application, please email **HCBS.waiver@maine.gov** for further direction.

Section 21 Prioritization
Priority One (1), Two (2) or Three (3)

Members who are put on the Section 21 waitlist shall be served according to priority levels

Section 21 Prioritization
Priority One (1)

Member meets Priority One (1) level if they are in need of Adult Protective Services

OR

- Primary Caregiver has reached the age of 65 or has a terminal illness **and**;
- Primary Caregiver is having difficulty providing necessary supports to the Member **and**;
- Has no other responsible or willing Caregiver

OR 

Section 21 Prioritization
Priority One (1), cont.

The Member meets at least **One (1)** of the Following Criteria and is at risk of **One (1)** other:

a. Within 12 Months the Member has demonstrated a significant medical/behavioral need by:

1. Functional Needs Have Increased
2. Involvement with the Criminal Justice System (not dependent upon conviction) that impacts or results in harm or threat to others
3. Prolonged or and unresolved crisis involvement resulting in high-risk for hospitalization
4. Three (3) or more hospital admissions over the last 12 months due to medical or behavioral decline that is expected to continue
5. The Health, Safety or Welfare of the Member or Others is at Imminent Danger

Section 21 Prioritization
Priority Two (2)

The Member does not meet Priority One (1) criteria, yet has been determined ***to be at risk for*** abuse, neglect, and/or exploitation in the absence of the provision of benefit services:

- A Member whose Primary Caregiver has reached age sixty (60) and is having difficulty providing the necessary supports to the Member in the family home; **OR**
- A Member living in unsafe or unhealthy circumstances but who is not yet in need of adult protective services, as determined by DHHS Adult Protective Services.

Section 21 Prioritization
Priority Three (3)

The Member is not at risk for abuse, neglect, and/or exploitation in the absence of the provision of benefit services:

- A Member living with family, who has expressed a desire to move out of the family home;
- A Member whose medical or behavioral needs are changing and who may not be able to receive appropriate services in the current living situation;
- A Member who resides with family, if the family must be employed to maintain the household but cannot work in the absence of the benefit being provided to the member; **OR**
- A Member who has graduated from high school in the State of Maine, has no continuing support services outside of the school system, but is in need of such services.

For more information please refer to the MaineCare Benefits Manual

https://www1.maine.gov/sos/cec/rules/10/ch101.htm

Things to Consider While Waiting

Funding for waiver services is not a guarantee and it may take years before a Member can access services. You may want to consider these options while waiting:

- **Natural Supports**
  1. Family
  2. Friends
  3. Community Activities
- **State Plan Services (MaineCare)**
  1. Residential Services (PNMI, Adult Family Care Services)
  2. Community Programs (Day Health Services)
  3. Nursing Services
  4. Nutrition
  5. Health
  6. Employment
- **Other Waiver Services (can only receive one (1) waiver at a time)**
  1. Other Related Conditions Waiver- Section 20
  2. Brain Injury Waiver- Section 18
  3. Adults with Disabilities Waiver- Section 19

Reconsideration of Priority

Section 21

Reconsideration of Priority for Section 21

When there is any significant change in the Member or caregiver's life, the case manager can submit an updated Section 21 Application Packet to the Waiver Manager to request a reconsideration of priority. Documentation should reflect the change and event(s) that have occurred.

Some changes include and should be documented in the plan:

- Involvement with Adult Protective Services (APS)
- Loss of Natural Support
- Living Situation
- New Diagnosis or Member's health is declining
- Caregivers age and their ability to support the members health and safety needs
- Caregiver is terminal

Reconsideration of Priority for Section 21

The Waiver Manager must receive:

- A completed **Section 21 Waiver Information Form (Word)**
- A completed **Personal Plan Update (Word)**, signed by the Individual/Guardian and the current Individual Service Plan (ISP).
- A completed **Yearly Cost Estimate for Services (Excel)**
- A completed **Developmental Services Home and Community Based Waiver Assessment (BMS-99) (Word)**

For these forms, please refer to:

http://www.maine.gov/dhhs/oads/provider/developmental-services/forms-protocols.html

Waiting List Notification Process

Section 21

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Aging and Disability Services
11 State House Station
41 Anthony Avenue
Augusta, Maine 04333-0011
Tel; (207) 287-9200; Toll Free: (800) 262-2232
Fax (Disability) (207) 287-9915; Fax (Aging) (207)287-9229
TTY: Dial 711 (Maine Relay

Annual Waiting List Notification

- Notification will be sent out by the Department the month the member was found Medically Eligible for Section 21.
- The notification will go to the Case Manager, Member and/or Guardian
- The Member has **6 months** to Confirm Interest in Remaining on the Section 21 Waiting List
- The Department will send out a **2nd Notice** to the Member, Guardian and their Case Manager 45 days after the Initial Notice to Remind the Member to **Confirm Interest**.
- If the Department has not heard a response within **6 months** the Member will be **removed** from the **Waiting List** and a Letter Issued to the Member and Guardian.
- The Member at any time can re-apply to be placed on the Section 21 Waiting List.

The Case Manager Must:

1. Convene a Meeting (phone or in-person) Include the Member, Guardian and/or other individuals the Member Designates to Discuss the Member's Needs. (If Necessary)
2. Discuss if Section 21 Funding is required to meet the Member's Needs
3. Assist the Guardian/and or Member fill out the Waiver Information Form

Only the Section is Necessary when completing the Waiver Information Form.

No additional documentation and/or assessments needed.

The form can be emailed to the Developmental Services Waiver Assistant or mailed to:

Developmental Services Waiver Assistant
c/o DHHS-OADS
41 Anthony Ave.
Augusta, ME 04333-0011

What To Do When An Offer Is Received

Section 21 &29

Choose to ACCEPT Offer
Section 21 & 29

- Member/Guardian (if applicable) will be notified by certified mail when an offer is made.
- Member/Guardian has **sixty (60) days** from the date of the funded offer to accept or decline the offer. Case Manager can notify the Waiver Manager of decision.
- Member must be using waiver services within **six (6) months** from the date of the offer.
- Failure by the Guardian and/or Member to Accept Services within sixty (60) days and/or use services within six (6) months will result in the offer being withdrawn per MaineCare Rule.
- ✓ If having **difficulty starting services** within the first four (4) months the Case Manager should email the Waiver Manager to discuss obtaining an extension.

Choose to DECLINE Offer
Section 21 & 29

- Waiver Funding and the services provided are voluntary. The Member and/or Guardian have the right to Accept or Decline Waiver Services.
- If **Declining** the Funded Offer: Case Managers, Guardian and/or Member must submit a Declination-Voluntary Termination of Waiver Services Form (Word) Form to the OADS Waiver Manager (Mail or Email).
- Some possible reasons to decline:
  1. Member leaving the State
  2. Member no longer interested in Section 21/29 Services
  3. Member would like to accept another MaineCare Waiver and/or Service

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Aging and Disability Services
11 State House Station
41 Anthony Avenue
Augusta, Maine 04333-0011
Tel: (207) 287-9200; Toll Free: (800) 262-2232
Fax (Disability) (207) 287-9915; Fax (Aging) (207)287-9229
TTY: Dial 711 (Maine Relay

Decline and Voluntary Termination of Home and Community Based Waiver Services

Click or tap to enter a date.

I/on behalf of, Click or tap here to enter text. EIS#: Click or tap here to enter text. MainCare ID#Click or tap here to enter text.

☐ **Decline Participation in** ☐ **Voluntary Terminate Participation in**

☐Section 21 Home and Community Based Waiver
☐Section 29 Home and Community Based Waiver

Declining Waiver Services

The applicant's name will be removed from the waiting list for the MaineCare waiver program(s) noted above. However, certain services including Case Management and Person-Centered Planning will not be affected by this decision.

Voluntary Termination of Waiver Services

Authorizations for these waiver services will be terminated. However, certain services including Case Management and Person-Centered Planning will not be affected by this decision.

Additionally, an application for Section 21 Waiver or Section 29 Waiver may be submitted in the future. Currently, there is a waiting list for Section 21 Home and Community Based Waiver and the Waiting List Protocol has been explained to me. DHHS will maintain a waiting list of eligible members for Section 21 who cannot receive these Home and Community Benefits because a funded opening is not available. The process to submit a new Section 29 application and the ability to receive a funded offer has been explained to me. Members who are on the waiting list and/or submitted a Section 29 application shall be served in accordance to the manner described in policy.

Reason for Declination and/or Voluntary Termination of Waiver:

Click or tap here to enter text.

Individual	Date
Guardian	Date
Guardian	Date
Case Manager	Date
Witness (If member is under Public Guardianship)	Date

CC: Waiver Manager: Click or tap here to enter text.
Assigned Resource Coordinator: Click or tap here to enter text.
OADS Waiver File/Central Office

Forms and Protocols

Current Forms and Protocols can be found at:
http://www.maine.gov/dhhs/oads/provider/developmental-services/forms-protocols.html

Waiver Forms for Children's & Mental Health Case Managers - Section 21 & 29

- Section 21 Waiver Information Form (Word)
- Section 29 Cover Sheet (Word)
- Yearly Cost Estimate for Services (Excel)
- Vendor Call Form (Word)
- Choice Letter (Word)
- Financial Cap on Services Calculator (Excel)
- Personal Plan Update (Word)
- Authorization Request Form (Word)
- Authorization Request Form (PDF)
- Developmental Services Home and Community Based Waiver Assessment (BMS-99) (Word)
- Service Proposal Request Form (Word)
- Ancillary Service Proposal Form (Word)
- Declination-Voluntary Termination of Waiver Services Form (Word)

Who To Contact With Questions

Cheryl Guimond LSW
Community, Mental Health and Children's Case Manager Liaison
Cheryl.Guimond@maine.gov
207-493-4116

Email any questions to Developmental Services Waiver Specialist
@ **HCBS.waiver@maine.gov**

Office of Aging and Disability Services
Maine Department of Health and Human Services
41 Anthony Avenue - State House Station 11
Augusta, ME 04333-0011